Vision and Medical History Record

Main Reason for Today's Appointment _____

Any Additional Concerns _____

Eye Health and Vision History

When was your last eye examination? _____ Dr. _____

Do you have glasses? No Yes

- ☐ Constant Wear
- ☐ As Needed
- ☐ Distance Only
- ☐ Close Work Only

Do you wear contact lenses ? No Yes

- ☐ Soft Lenses
- ☐ Gas Perms
- ☐ I remove lenses at night
- ☐ I leave lenses on when I sleep

How well do you see with your present glasses and/or contacts?

Far away _____ Close up _____

Are you experiencing excessive eye discomfort No Yes

- ☐ Burny
- ☐ Itchy
- ☐ Red Eyes
- ☐ Scratchy
- ☐ Watery
- ☐ Filmy

Have you had any eye diseases or eye injuries? No Yes

_____

_____

Is there family history of any eye diseases? No Yes

_____

_____

Health History

Name of family doctor _____ Date of last physical _____

Do you have any problems with any of the following systems? If yes, please check box.

- ☐ Gastrointestinal
- ☐ Ear/Nose/Throat
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Skin
- ☐ Mental
- ☐ Endocrine (Glands)
- ☐ Nervous System
- ☐ Headaches
- ☐ Genitourinary
- ☐ Musculoskeletal
- ☐ Blood/Lymph
- ☐ Allergic / Immunologic

Please list all MEDICATIONS that you are presently taking.

_____

_____

_____

_____

_____

_____

_____

Please list any ALLERGIES to medications and substances

_____

_____

_____

_____

_____

_____

_____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature _____ Date _____

Doctor's Notes _____

_____

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